TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Heckman, Michael

Respondent Name
Truck Insurance Exchange

MFDR Tracking Number
M4-16-3355-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
July 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted

Amount in Dispute: $3,116.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on July 14, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2015	Surgery	$3,116.00	$1,041.88

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out time frames for submission of medical claims.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services

performed in a facility setting.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – Time limit for filing claim/bill has expired
   - R89 – CCI: Misuse of Column 2 code with Column 1 code
   - 236 – This proc or proc/mod combo not compatible w/another proc on same day
   - 18 – Duplicate Claim/Service
   - W3 – Appeal/Reconsideration
   - 51 – Multiple Procedure

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – "The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." While neither party submitted a position statement for this dispute, the documentation found within this dispute was:

   - Review of the medical claim included in this dispute, found in box 31, a date of 10/22/2015.

   As the date of service was September 24, 2015, the date found on the medical claim of October 22, 2015 was within the time limit for claim submission. For that reason, the health care provider met the requirement to submit the medical bill not later than 95 days after the date the disputed services were provided. The services in dispute will therefore, be reviewed per applicable rules and fee guidelines.

2. Procedure code 29881, service date September 24, 2015, represents a professional service performed with place of service code (22) Outpatient Hospital with 28 Texas Administrative Code §134.203(c)(1) states in pertinent part,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > > For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery… For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service annual conversion factor) or $70.54.

   The applicable allowable found at www.cms.hhs.gov is $530.74 is multiplied by the Division conversion factor of $70.54/Medicare Conversion factor or $35.9335 or 70.54/35.9335 x $530.74 = $1,041.88

   28 Texas Administrative Code §134.203 (b)(1) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > > Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;

   Per National Correct Coding Initiatives found at www.cms.hhs.gov finds submitted code 29874 has a conflict with submitted code 29881. No separate payment is recommended.

3. The total allowable reimbursement for the services in dispute is $1,041.88. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $1,041.88. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds additional reimbursement is due. As a result, the amount ordered is $1,041.88.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,041.88, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.